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ABSTRACT

A group of depressed women outpatients who were attending the outpatient clinic of a Midwestern state hospital were assigned women volunteers who had been trained in either problem solving and Rogerian relationship techniques or cognitive-behavioral therapy. Volunteers met with patients at least one hour per week. Patients were assessed on various rating scales after a three month and six month interval in order to determine if their depressive symptomatology and subjective feelings of helplessness and hopelessness had lessened. No statistically significant difference was found between patients receiving the two types of counseling, but it was found that, taken as a group together, the patients showed maximum improvement after three months which was maintained but not improved upon up to the six month assessment point. It is planned to compare these patients with a control group who have not been assigned a volunteer, and to reassess them again after an 18 month time interval. (Author)

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Volunteer Effectiveness in Counseling Chronically Depressed Women Outpatients

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Within the mental health professions there has been a recent movement towards dealing with psycho-social problems within the community in which they occur; where individuals of all socio-economic levels experience emergencies of all kinds. These persons in distress benefit from having someone to turn to who is able to respond immediately and at any time. In the middle 1960's suicide prevention and crisis intervention centers were established in this country utilizing non-professional volunteer workers as a major resource in providing counseling services to people in acute distress. These non-professional counselors bring with them a fresh enthusiasm and open-mindedness which may have been obliterated in the professional curricula of medical, psychology and social work schools and a readiness and willingness for personal involvement without the constraints of the usual eight hour working day. Whatever the reason the non-professionals, coming from a great variety of backgrounds, are proving to be an essential element in the success of many new programs designed to meet service needs in the community.

The opportunities and situations for using volunteers in crisis and mental health interventions and other human service roles have expanded rapidly in the last two decades and volunteers are now utilized in face-to-face crisis intervention, in outreach, in disaster situations, and in psychotherapy roles, as well as being extensively utilized as hot-line workers. However, evaluative research

1. In: Mohr, M.G. Proceedings of the Eleventh Annual Meeting; American Association of Suicidology, New Orleans, Louisiana, April, 1978. Houston, Texas: American Association, of Suicidology, 1979.

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has lagged the prodigious service advances and volunteers have also been under utilized in traditional mental health settings.

There are problems in selection and evaluation of both clients and non-professional volunteer counselors and this study had the following purposes:

1. To demonstrate the effectiveness of volunteers with chronically depressed outpatients in a traditional mental health setting.
2. To contrast the effectiveness of two volunteer roles with this patient group: one group was trained in a typical crisis intervention hotline style, a blend of a problem solving approach and a Rogerian client-centered relationship approach, while a second group was trained to use cognitive behavior therapy.

Method

Subjects: There is a group of depressed women who present themselves to the St. Louis State Hospital Outpatient Clinic needing attention for an extended period of time. Some of them require brief inpatient treatment and some do not, but they do not respond to anti-depressant medication alone and they tend to return to the hospital with recurrent depressive episodes.

They tend to be in their middle thirties, age range 21 to 51 years, mean age 35.9 years ($\pm$ S.D. 7.99), have school age children, chronic marital problems, and are frequently separated or in the process of divorcing. This sample comes from the lower social classes, (as derived from the Hollingshead two-factor index of social psoition), and they have a variety of diagnoses including; depressive neurosis, manic depressive disease, passive-aggressive personality, marital maladjustment and adjustment reaction(as defined in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders second edition). Many of them have more than one diagnosis and these diagnoses tend to change from time-to time. They are on either anti-depressant medication, tranquilizers or both and many of them have made parasuicides (i.e. suicide attempts). They are

frequently experiencing financia difficulties, are demoralized, self-destructive, feel hopeless and are unable to cope with ordinary routine daily problems. All subjects were diagnosed as non-psychotically depressed (i.e. no delusions or hallucinations) but they all had overt depressive symptoms on the Missouri Standard System of Psychiatry Mental Status Form; the Hamilton Depression Rating Scale, the Beck Hopelessness Scale and the Missouri Standard System of Psychiatry Symptom Check List. This latter symptom check list is derived from the Hopkins S.C.L. 90. Patients were assigned to one of three groups in order to counterbalance the following characteristics: depth of depression, prior parasuicides; age, marital status; educational level, social class and accessibility to psychotherapy. In order to assess accessibility to psychotherapy we drew up a 14 item rating scale which was based on factors which various authors have stated to be relevant to a positive outcome in psychotherapy. We have attempted to validate this new scale by computing correlations between it and the Barron Ego Strength (Es) sub-scale of the shortened from the MMPI; and the difference score between patients initial rating and six month rating on each of the outcome dependent measures used to rate progress. Although no significant correlation was found in any of these computations, we did use it for matching purposes.

Procedure

The three groups were; Group I an experimental group assigned volunteers trained in problem solving and Rogerian relationship techniques, age range 24 - 46 years, mean age 34.4 yrs. (± S.D. 6.88); Group II an experimental group assigned volunteers trained in cognitive-behavioral therapy, age range 21-51 yrs., mean age 37.5 yrs. (± S.D. 9.03), and a Group IIIcontrol group which was assigned to professionally trained counselors. All patients continued to see a psychiatrist monthly for short medication evaluations and over the period of the study, these psychiatrists tended to change due to their rotating out of the outpatient clinic.

Women volunteers were randomly assigned except for age to one of the two experimental groups. As with their clients many were in their middle 30's, range 19-50 years, mean age 32.68 yrs. (± S.D. 8.14); Group I, range 19-50 yrs, mean age 33.9 yrs (± S.D. 9.07) and Group II range 23-48 yrs, mean age 31.33 yrs. (± S.D. 7.26). They tended to come from higher social classes and it just so happened that a slightly higher proportion of those assigned to Group I had completed divorce from their husbands as compared with those assigned to Group II. Their mean last grade completed was higher than those of their clients, and in terms of age, educational level, and social class they were fairly well matched with each other

Training for each group consisted of 8-hours pre-service, and 3-hours in-service training and supervision per month for at least six months. Each volunteer was assigned a patient who they agreed to see for a period of at least six months at a frequency of at least one hour per week. The volunteer also agreed to be available by telephone when needed. The initial meeting of patient and volunteer took place at the hospital, but subsequent meetings were arranged for mutual convenience and most of them took place away from the hospital. The patients were assessed on various rating scales on three occasions. The first being as close in time as possible to the initial presentation to the hospital; the second after three months; and third after six months. A fourth assessment will be done after an additional year, (i.e. eighteen months after initial presentation). Any patient withdrawing from the program before completing the full six months was assessed at that time and also at the same time intervals. The patient and psychiatrist were also asked to assess the usefulness of their volunteer counselor and the counselor was also asked to assess her own progress on these same three occasions.

Results

At the present time, the results of the ratings on the two experimental groups

can be presented but the data on the control group has yet to be analyzed. Table I shows the means of the outcome dependent measures at the initial, three months and six months intervals for each group separately and combined.

Insert Table I

The means of each rating scale show a reduction at the three month period for each group individually and combined. This reduction is not continued, however, through to the six month period on the Beck Hopelessness Scale with Group II alone, or with both groups combined; or on the Hamilton Depression Scale with Group I, each of which show a slight increase. However, the reduction in scores continued through on the other rating scales. Both groups started out at the initial assessment fairly well matched except for Group II which showed a greater score on the Hamilton Depression Scale. This scale which measures psychiatric symptomatology was rated blind as the rater did not know the group membership of the patient he was rating. The Derogadis Factor and the Evenson Factor are similar sub-scales of depression of the Missouri Symptom Check List which were derived by factor analysis and they involve many of the same items which seem to measure depression and anxiety. The Mental Status Scale is a measure of gross pathology (i.e. not only depression) and the Lonliness item was taken as a single item from the Missouri Symptom Check List. The full Missouri Symptom Check List is a self-rating scale, derived from the S.C.L. 90, of which the total score is also a measure of total pathology. The Accessibility to Psychotherapy Scale and the Mental Status forms were filled in by the patient's psychiatrist and as already stated the Hamilton Rating Scale was completed blind by an independent rater. The Beck Hopelessness Scale is a self-rating scale, like the Missouri Symptom Check List.

Insert Table II

Table II shows the results of a two-factor mixed design analysis of variance

Table of Means and Standard Deviations of Outcome Dependent Measures at Initial, Three Month and Six Month Intervals, of Group I and Group II and Group I & II

Scale	I Initial $\bar{x}$ ± S.D.	II Initial $\bar{x}$ ± S.D.	I & II Init $\bar{x}$	I 3 Month $\bar{x}$ ± S.D.	II 3 Month $\bar{x}$ ± S.D.	I&II 3 Month $\bar{x}$	I 6 Month $\bar{x}$ ± S.D.	II 6 Month $\bar{x}$ ± S.D.	I&II 6Mo $\bar{x}$ ± S.D.
Accessibility to Psychotherapy 0 - 42	26.4±5.12	23.3±4.13		-	-	-	-	-	-
Beck Hopelessness Scale 0 - 20	14.6±4.7	12.1±6.4	13.35	10 ± 6.9	8.3 ± 6.9	9.15	9.5 ± 7.6	9.77±8.4	9.63
Derogadis Factor 0 - 52	36.8±11.3	35.2±10.9	36	28.3±17.1	28.4±13.7	28.35	23.6 ± 16	27.1±16.4	25.26
Evenson Factor 0 - 56	39.9±11.9	38.9±10.2	39.4	38.9±17.4	30.8±14.8	30.85	25.6 ± 16	30.7±18.1	28
Missouri Symptom Check List 0 - 360	188.7±74.8	199.4±78.6	184	140.3±78.1	138.7±86.9	144.26	113.3± 66	132.6±97.9	122.42
Hamilton Rating Scale 0 - 52	16.9±6.3	20.3±5.6	16.35	12.1±7.2	15.2±7.1	14.23	13.1± 8.4	14.88±7.4	13.1
Mental Status 0 - 32	15.9±6.6	16.7±13.96	16.4	10.22±6.3	9.5±8.4	9.88	5.67±6.6	8.28±9.1	6.8
Loneliness Item 0 - 4	3 ±1.41	3.5± .85	3.25	2.2 ±1.62	2.8±1.55	2.5	1.7 ±1.49	2.4 ±1.67	2.05

Table Of Two-Factor Mixed Design Analysis Of Variance Within Subjects

SCALE	Between Conditions		Within Subjects		Interaction		Rank Order of Sensitivity
	F	P	F	P	F	P	
Beck 6/12 (3 points) (n = 19)	0.281	NS	4.262	0.025	0.636	NS	4
Derogatis 6/12 (3 points) (n = 19)	0.003	NS	6.297	0.01	0.572	NS	2
Evenson 6/12 (3 points) (n = 19)	0.015	NS	6.840	0.005	0.780	NS	2
Mo. Symptom Check List (3 points) (n = 19)	0.002	NS	6.856	0.005	0.836	NS	2
H.D.S. (3 points) (n=18)	1.436	NS	5.222	0.025	0.044	NS	3
M.S. (3 points) (n = 15)	0.583	NS	11.044	0.0005	2.85	0.10	1

within subjects on the various dependent outcome measures using the initial rating scores the three month and the six month rating scores. It seems that there is no statistically significant difference between the experimental groups in terms of improvement on any of the rating scales, but taking both groups together there is improvement shown within subjects on all the rating scales with the Mental Status showing the greatest change and the Hamilton Depression Scale and the Beck Hopelessness Scale the least.

In order to be sure of this, we did a t-test for correlated means on outcome dependent measure differences between initial rating scores and three month rating scores and between three month rating scores and six month rating scores and between initial and six month rating scores, again on each group separately and combined.

Insert Table III

It seems that most of the significant improvement on these rating scales took place in the first three months and no statistical improvement occurred within the second three months. However, over the six month period a statistically significant improvement was maintained except with Group II on the Beck Hopelessness Scale, the Derogadis Factor, the Evenson Factor, the Missouri Symptom Check List and the Hamilton Depression Rating Scale. The Hamilton Depression Scale does not show an overall improvement of statistical significance with Group I or Group II taken separately after six months but there is improvement within subjects with both groups combined. With these analyses the number of the sample is small and so the significance estimation may be an underestimate of the actual improvement that has occurred. This possibility is borne out by the fact that on the Hamilton Depression Scale significant improvement is found when both group six month difference scores are combined, whereas, no significance is found when they are taken separately and the (n) is only 9 or 10.

Discussion

Volunteers have been shown in this study to be effective in the overall

T-test for Correlated Means on Outcome Dependent Measure Differences Between Initial Rating Scores and Three Month Rating Scores and Between Initial and Six Month Rating Scores.

Difference between initial and 3 months					Difference between initial and 6 months				
(n)	$\bar{d}$	± S.D. d	t-test	Sig.	(n)	$\bar{d}$	± SD. d	t-test	Sig.
	Beck I					Beck I			
10	4.6	7.53	1.93	.10	10	5.1	6.31	2.55	.05
	Beck II					Beck II			
10	3.8	6.71	1.79	NS	9	1.78	8.30	0.64	NS
	Beck I&II					Beck I&II			
20	4.2	6.95	2.70	.02	19	3.53	7.31	2.10	.05
	Derog. I					Derog.I			
10	8.5	12.05	2.23	.10	10	13.2	11.50	3.63	.01
	Derog II					Derog II			
10	6.8	14.86	1.45	NS	9	6.89	16.30	1.27	NS
	Derog I&II					Derog I&II			
20	7.65	13.99	2.59	.02	19	10.21	13.95	3.19	.01
	Even I					Even I			
10	9.0	12.59	2.26	.05	10	14.3	10.07	4.49	.01
	Even II					Even II			
10	8.1	14.79	1.73	NS	9	7.0	17.79	1.18	NS
	Even I & II					Even I & II			
20	8.55	13.37	2.85	.02	19	10.84	14.33	3.20	.01
	MSCL I					MSCL I			
10	48.4	69.88	2.19	.10	10	75.4	71.81	3.32	.01
	MSCL II					MSCL II			
10	40.7	74.62	1.72	NS	9	35.00	82.95	1.26	NS
	MSCL I & II					MSCL I & II			
20	44.55	70.47	2.83	.02	19	56.26	77.88	3.15	.01
	HRS I					HRS I			
10	4.8	5.65	2.68	.05	10	3.75	6.59	1.80	NS
	HRS II					HRS II			
9	5.444	9.87	1.65	NS	9	5.44	8.819	1.85	NS
	HRS I & II					HRS I & II			
19	5.105	7.71	2.88	.01	19	4.55	7.55	2.63	.02
	MS I					MS I			
9	6.222	8.93	2.09	.10	9	10.55	9.40	3.37	.01
	MS II					MS II			
8	11.125	14.44	2.179	.10	7	14.86	11.42	3.44	.02
	MS I & II					MS I & II			
17	8.529	11.721	3.00	.01	16	12.44	10.20	4.87	.001

treatment of chronically depressed women the improvement being achieved by three months and maintained to six months. Those trained to do client-centered crisis intervention therapy have had better results than those trained to use cognitive behavioral techniques although this was not found to be statistically significant. This lack of statistical significance may be due to the small number of patients included in the study. No volunteer seems to have made her patient worse.

Patients, psychiatrist and volunteers have all expressed confidence in the worth of this additional service and patients do seem to feel better about themselves as a result of this befriending. In terms of self reports about feelings of self worth and hopelessness, the first three months seem to have seen the most progress and this is also true, although less so when clinical symptoms of depression are looked at. It is know from other studies that the benefits of psychotherapy in terms of improved functioning and interpersonal relationships may not show up until after at least a six month period and we await with interest the eighteen month follow-up assessments and the results of analysis of the data from the control group.

The data thus far shows that volunteer counselors have been effective with chronically depressed women outpatients and the fact that volunteers from the community are available, easy to recruit and keen to participate in a program such as this highlights the fact that this valuable resource for therapy is at present under utilized in mental health settings.